PRINTED: 06102/2016
FORM APPROVED

Division of Health Care r=adlities

STATEM NT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE: SURV Y COMPLETED
	TN19011	A. BUILDING: _____ B. WING _____	05/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF JOHNSON CIn	140 TECHNOLOGY LANE JOHNSON CITY, TN 37804

(X4) ID PREFIX TAG	SUMMARY STAT MENT OF DEFICI,NCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PIAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During the annual Licensure suvey conducted from 5/16/16 through 5/16/16 at Chrisllan Care Center of Johnson City, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes-	N 000		

Division of Haalln Caro tacilities
LABORATORY DIREICTORIS OR PROVIDER/SUPPLIER REPRESENTATIVE.'S SIGNATURE

TITLE: Executive Directo

(X6) DATE: 06/08/2016

STATE FORM 1111 NE5811